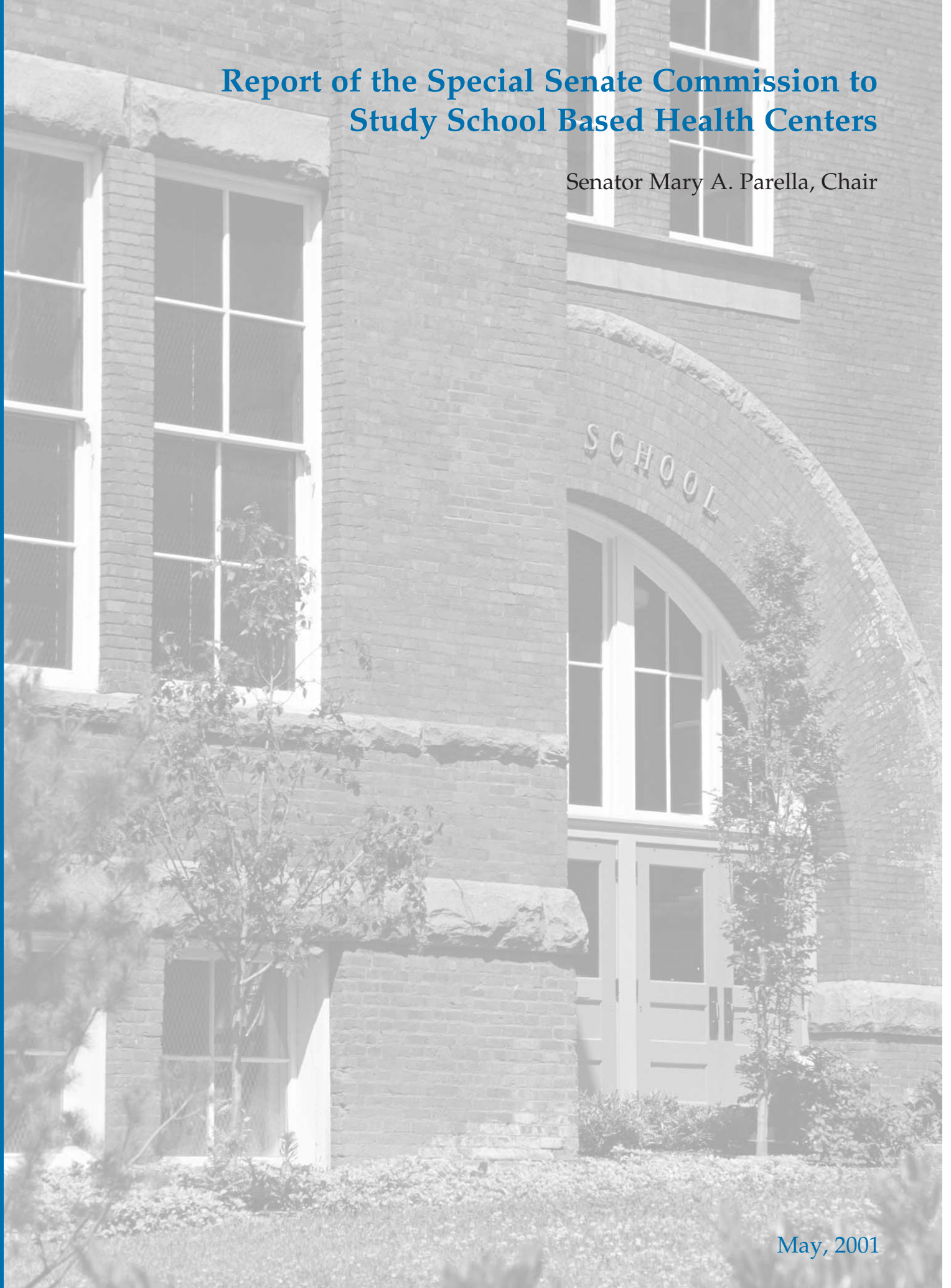
Report of the Special Senate Commission to Study School Based Health Centers

Senator Mary A. Parella, Chair



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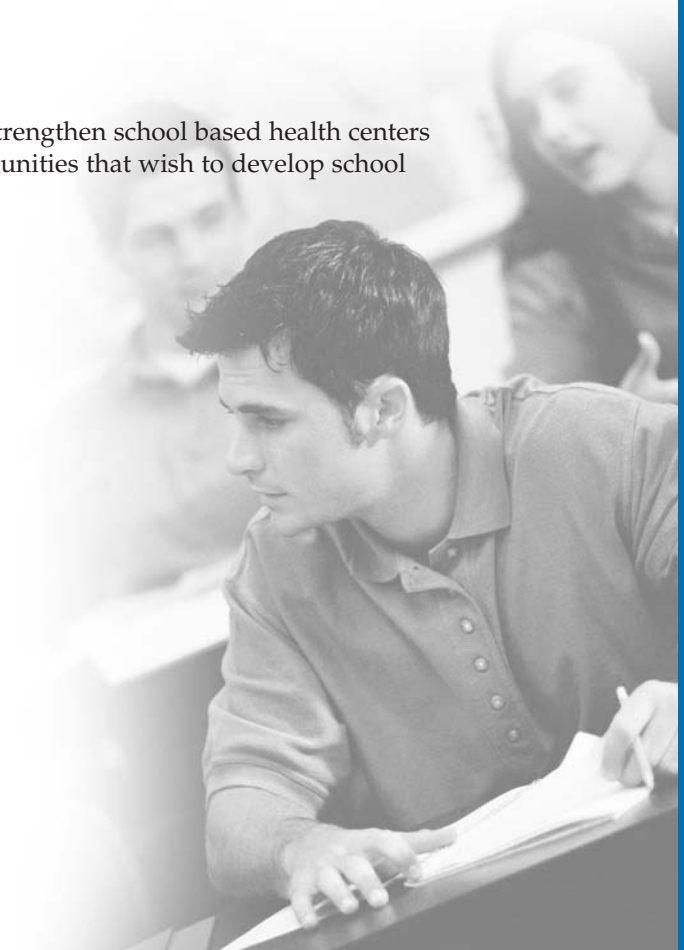
School based health centers have grown rapidly throughout the country as an effective means to provide health and mental health services to adolescents. There are now approximately 1500 Centers in other states, and seven in Rhode Island.

On June 25, 1999, the Rhode Island General Assembly created a Special Senate Commission to Study School Based Health Centers. The Commission developed nine recommendations to improve and strengthen school based health centers across the State. The following is the list of the recommendations developed by the Commission:

1. Enact enabling legislation, during the 2001 legislative session, that establishes criteria for the continuation and expansion of school based health centers.
2. Establish a line item in the state budget to support the School Based Health Center Initiative.
3. Establish a separate license procedure for school based health centers to assure continued operation by licensed health care facilities and inclusion in managed care and private insurance plan networks.
4. Establish incentives to engage local medical providers and health care institutions in the School Based Health Center Initiative.
5. Engage partners to ensure that school based health centers are an integral part of the health care system for children and adolescents in Rhode Island.
6. Expand behavioral health capacity at school based health centers.
7. Work to add oral health as an essential component of school based health center services.
8. Initiate a comprehensive review, under the direction of the Children's Cabinet, of all school health services and develop a funding strategy to ensure that each school can meet the medical, behavioral and oral health needs of students.
9. Continue administration of the School Based Health Center Initiative by the Rhode Island Department of Health in collaboration with other state departments.

Implementation of the Commission's recommendations will strengthen school based health centers and provide a strong foundation for expansion to other communities that wish to develop school based health centers.



School based health centers play a critical role in improving the lives of children and adolescents. The Centers increase the number of children who actually receive care, which is especially important in our cities where there are high numbers of teens with unmet health and mental health needs.

Most teens are not comfortable with the adult or pediatric systems of care. Both the adult and pediatric systems are ill suited to deliver the multi-disciplinary, preventive, and time-intensive care adolescents need. Therefore, adolescents have the lowest utilization of health care services of any age group. Even when adolescents are insured, they do not receive the services they need most. The Commission heard testimony that teens triple their annual health contacts when they enroll at a school based health center.

The most common health problems affecting teens today, injuries, chronic illnesses such as asthma, and mental health problems, are all preventable. In addition, many teens engage in risky behaviors like smoking, drinking alcohol, substance use, and early sexual involvement. Access to primary care is critical in managing these problems and can reduce emergency room use. All of these issues can be effectively addressed where teens spend most of their day—in school.

Teens from low-income families face additional challenges. According to Rhode Island Kids Count data, our urban communities have the highest rates of teenage pregnancy; sexually transmitted diseases; tobacco, alcohol, and other substance use; and intentional and unintentional injuries. School absenteeism and drop out rates are highest in central city schools where poverty rates are the highest.

Preliminary data from the school based health centers in Rhode Island indicate students enrolled had better attendance in all age categories compared to non-enrollees. In the end, a strong and expanded school based health center system will reduce school absences and therefore directly impact the success of students and schools across the state.

Rhode Island opened its first school based health center in Providence's Central High School in 1987. Since that time, six new school based health centers have been established - one in an elementary school, two in middle schools, and three in high schools - bringing the total number of Centers to seven.

Funding to open the Centers has come from a variety of sources. The Central High School Center was started with a special legislative grant. The Department of Health used a special allocation of Maternal and Child Health funds to open the state's second school based health center at the Woonsocket Middle School. Central Falls High School was awarded funding from the federal Healthy Schools/Healthy Communities grant program to open its Center. In 1997, the Rhode Island Department of Health received a Robert Wood Johnson Foundation Making the Grade Program grant to establish four additional Centers in Pawtucket and Woonsocket.

The School Based Health Center Initiative in Rhode Island is at a critical juncture. The seven Centers are struggling to continue offering services that address the complex health and social needs of their children and youth. In March 2000, Central Falls' federal funding ended; thankfully, the Rhode Island General Assembly intervened and provided funding to assure ongoing operations. With four additional school based health centers rapidly approaching the end of their Robert Wood Johnson Foundation funding, the Rhode Island General Assembly created a Special Senate Commission to Study School Based Health Centers. The purpose of the Commission was to:

- Develop long term funding strategies to ensure adequate financial support for school based health centers.
- Study the relationship of the Centers' services to RIte Care, the Integrated Services Initiative, and special education programs.
- Study the potential for integration of mental health, substance abuse, and oral health services into the Centers.

The Commission met twelve times between November 1999 and June 2000. A subcommittee worked to develop a funding plan. Commission members accepted the final report on January 24, 2001.

A list of Commission members and their affiliations can be found in Appendix 1 and a list of participants who provided expert written and oral testimony can be found in Appendix 2. Appendix 3 contains a summary of research on the effectiveness of school based health centers in improving key health and education indicators. Appendix 4 summarizes "Creating Access to Care: National School Based Health Center Census 1998-1999".

The report of the Special Senate Commission to Study School Based Health Centers includes the following recommendations:

Enact enabling legislation during the 2001 legislative session that establishes criteria for the continuation and expansion of school based health centers. 1

Rationale:

School based health centers lack official recognition in state law, despite their existence and demonstrated effectiveness in improving access to health care for the state's children and youth.

To address this gap, the Commission recommends that the General Assembly pass enabling legislation in the 2001 session. In addition to incorporating the Senate Commission's recommendations, the legislation should include the following elements:

- ***Annual report to the legislature.*** The report should include indicators of success such as enrollment and utilization data as well as outcome data such as days lost from school. The report should build upon national models and incorporate relevant state data.

- ***Funding criteria.*** Criteria need to be developed to offer funding to those communities that will benefit most from the school based health centers. At a minimum the criteria should include demonstration of community need, community support, ability to meet Rhode Island Guidelines for School Based Health Centers, and participation in the Rhode Island Assembly of School Based Health Care.

- ***Funding provisions.*** The legislation should establish core state funding for school based health centers and make provisions for receipt of such funding including the requirement of a cash match and specified in-kind services. The legislation also should allow for the inclusion of other funding streams, as they develop or as deemed appropriate.

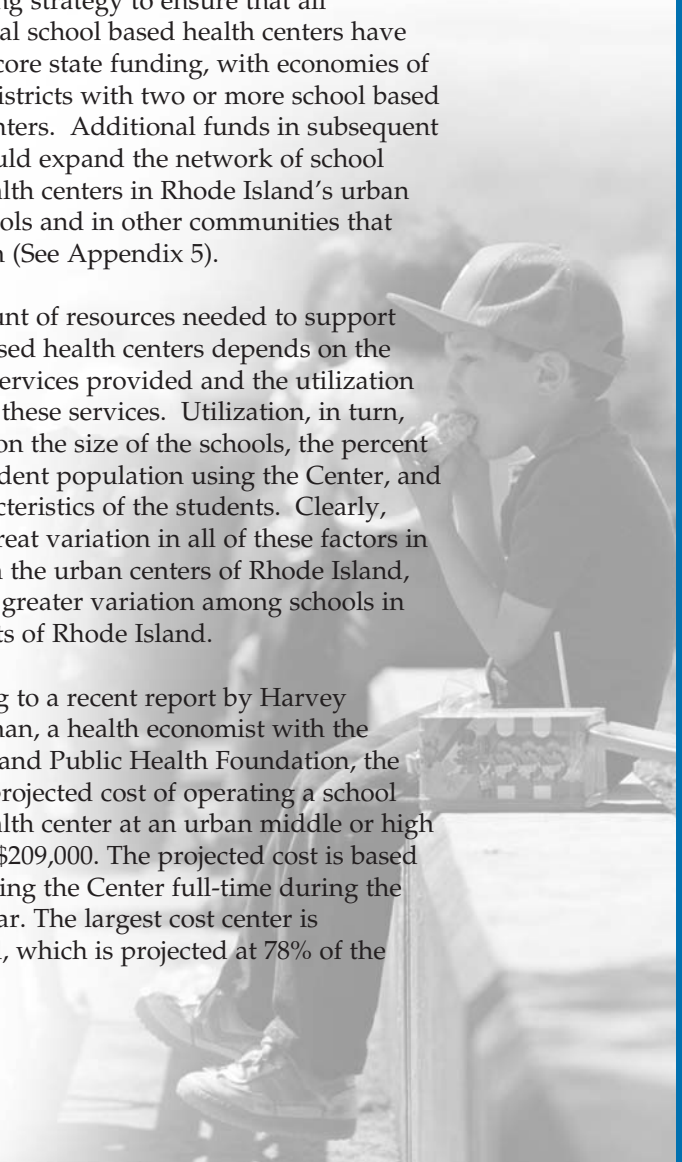
Establish a line-item in the state budget to support the School Based Health Center Initiative. 2

Rationale:

The Commission recommends a multi-year funding strategy to ensure that all operational school based health centers have $125,000 core state funding, with economies of scale in districts with two or more school based health centers. Additional funds in subsequent years would expand the network of school based health centers in Rhode Island's urban high schools and in other communities that seek them (See Appendix 5).

The amount of resources needed to support school based health centers depends on the types of services provided and the utilization levels for these services. Utilization, in turn, depends on the size of the schools, the percent of the student population using the Center, and the characteristics of the students. Clearly, there is great variation in all of these factors in schools in the urban centers of Rhode Island, and even greater variation among schools in other parts of Rhode Island.

According to a recent report by Harvey Zimmerman, a health economist with the Rhode Island Public Health Foundation, the average projected cost of operating a school based health center at an urban middle or high school is $209,000. The projected cost is based on operating the Center full-time during the school year. The largest cost center is personnel, which is projected at 78% of the



total budget, with other direct expenses (medical supplies, lab, etc.) projected at 9%. Administrative expenses are projected at 13% (See Appendix 6 for a full copy of the report). The projected budget assumes that both the school and sponsoring medical organization make in-kind and cash contributions to support the Center. For example, it is expected that the schools provide space, utilities, janitorial services, additional supplies, other school department personnel such as school psychologists or counselors, and so forth. It is also expected that the sponsoring medical organizations will contribute overhead support and services such as billing and provision of 24 hour/7 day coverage and coverage of students when school is not in session.

National research shows that to be cost effective, school based health centers must serve a student population of at least 800 to 1,000 students. Therefore, small schools could partner with a larger school to be eligible. This partnering will be necessary as the number of charter schools and alternative schools continues to grow. These schools tend to be smaller in size, yet may serve populations that could benefit most from school based health care.

Revenue sources for school based health centers vary (See Table 1). In general, it is expected that the state will provide core funding. Some reimbursement is available from health insurance and other third party sources. Even with core state support, it is expected that both schools and their medical partners will be important sources of financial support.

Establish a separate license procedure for school based health centers to assure continued operation by licensed health care facilities and inclusion in managed care as well as private insurance plan networks.

Rationale:

School based health centers are operated by Rhode Island licensed health facilities and must comply with all relevant state and federal laws and regulations. They must meet provider licensing requirements; facilities requirements; clinical, administrative, operational, and other requirements as spelled out in the Rhode Island Guidelines for School Based Health Centers.

The Commission recommends Centers be staffed with licensed credentialed providers who meet health plan requirements, to maximize reimbursement for provided services. Conversely, commercial health plans, as well as Medicaid and RIte Care health plans, should include all school based licensed and credentialed behavioral health providers in their networks. Given school based health centers designation as essential community providers under RIte Care, Center staff should not be excluded from health plan credentialing due solely to limits on provider networks.

The Department of Health is developing a separate licensing procedure for school based health centers.

Table 1
Prototype Budget - FY 2002
School Based Health Center Revenues

Projected Revenues	*Cash*	*Inkind*	*Total*	*Percent*
Insurance and Others Fees	$ 14,600	$ 0	$ 14,600	7%
School Department	$ 25,000	$ 21,900	$ 46,900	22%
Medical Provider	$ 0	$ 22,500	$ 22,500	11%
State Contribution	$ 125,000	$ 0	$ 125,000	60%
Total	**$ 164,600**	**$ 44,400**	**$ 209,000**	**100%**

Establish incentives to engage local medical providers and health care institutions in the School Based Health Center Initiative. 4

Rationale:

Integration of school based health centers in Rhode Island's health care environment is critical to the ongoing success of school based health centers. Primary care providers have the capacity to refer and manage care including coverage on evenings and weekends through the operating health facility's main site.

The Commission recommends that the Rhode Island Department of Health establish incentives to encourage the participation of local medical providers and health care institutions. The Commission recommends the following incentives be considered:

Hospital Community Benefit Incentives

The Hospital Conversions Act (RIGL 23-17.14) requires that all hospitals in Rhode Island submit a report annually to the Rhode Island Department of Health of their community benefit activities. Hospitals can meet community benefit requirements by serving as the operating agency for a school based health center or by providing direct support of community health center sponsorship. The Commission recommends that the Department of Health assist interested hospitals in pursuing this option.

Best Practice Incentives

Rhode Island's experience shows that adolescents who receive services at school based health centers are seen for three or more visits per year, whereas adolescents receiving services from other community-based providers are seen less than once a year on average. Reimbursement and managed care capitation rates for adolescents discourage more frequent visits.

School based health centers should be driven by best practices rather than what is reimbursable. When service levels are built on reimbursement systems, they often do not meet the needs of students and families. Also, once established, reimbursement systems are difficult to change. Given the difference in utilization and best practice recommendations for adolescents, the Commission recommends that incentives be developed for provider organizations to enroll more students in school based health centers.

RIte Care Financing Incentives

The Department of Human Services, which has identified school based health centers as essential community providers in the RIte Care Program, should work with the Department of Health to ensure their successful integration into Rhode Island's health care environment, now and into the future.

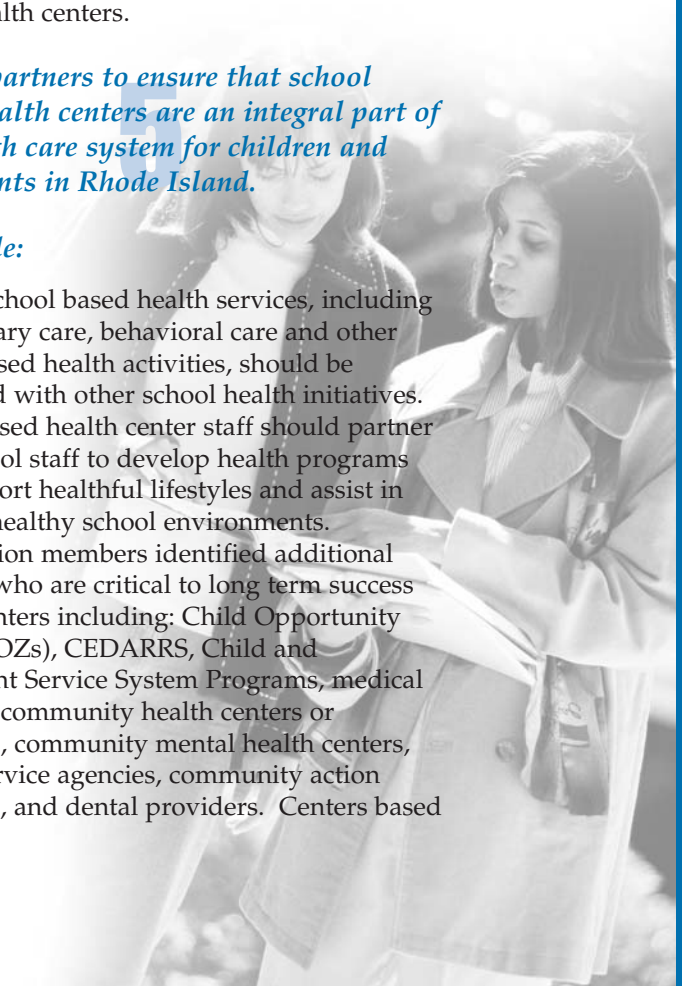
While all of the school based health centers have contracts with the RIte Care health plans, the reimbursement provisions of these contracts vary, with only one plan contracting with the Centers for services on a capitated basis. The remaining health plans reimburse on a fee-for-service basis. In both cases, however, the reimbursement is only a fraction of the true cost of providing the services.

The Commission recommends that the RIte Care contracts enhance the capitation payments and reimbursement rates received by school based health centers.

Engage partners to ensure that school based health centers are an integral part of the health care system for children and adolescents in Rhode Island. 5

Rationale:

Core school based health services, including primary care, behavioral care and other school based health activities, should be integrated with other school health initiatives. School based health center staff should partner with school staff to develop health programs that support healthful lifestyles and assist in creating healthy school environments. Commission members identified additional partners who are critical to long term success of the Centers including: Child Opportunity Zones (COZs), CEDARRS, Child and Adolescent Service System Programs, medical partners (community health centers or hospitals), community mental health centers, family service agencies, community action programs, and dental providers. Centers based



in elementary schools should also connect with the preschool provider community and Head Start programs.

The Commission recommends that partnership agencies closely coordinate services to maintain a level of care that meets student and family needs. Best practices for service coordination should be shared to enable communities to implement strategies that will work in their schools.

6 Expand behavioral health capacity at school based health centers.

Rationale:

A recent study of Massachusetts' school based health centers showed that adolescents identified and referred for mental health services significantly decreased their rates of absences and tardiness. Rhode Island's experience confirms the importance of behavioral health services as part of school based health centers.

Nationally, behavioral health visits account for 50% of total school based health center visits. In Rhode Island, behavioral health visits account for less than 30% of all visits with the majority being one to one counseling sessions. School based health center staff members want to expand the number of group sessions that are presently offered. Expanded hours and space in the school will enable the formation of more behavioral group therapy.

While some schools currently have behavioral health providers, the amount of direct service to students is often limited and capacity is inadequate to meet the needs of the student population. Psychiatrists, counselors, and social workers have varying roles across districts. School based health centers can expand access to confidential outpatient counseling for students in school. Behavioral health capacity, including more definitive behavioral and mental health services should be expanded at each Center, with services provided by licensed credentialed providers.

The Commission recommends that school districts also contract with a psychiatrist to assess school behavioral health needs, expedite clinical evaluations for medications, and address other behavioral health issues. This proposed contracting model is similar to that which schools use to provide medical and dental consultation and services.

Centers should develop formal linkages with schools of social work and psychology to increase service capacity and prepare future school based health providers.

7 Work to add oral health as an essential component of school based health center services.

Rationale:

Children and adolescents who receive inadequate levels of dental care can develop long term oral health problems. Chronic dental problems can lead to poor health, poor self-image, lack of concentration, absenteeism, and reduced school performance.

Children who do not have dental insurance are three times more likely to have untreated dental disease than children who have dental insurance. While all children enrolled in RIte Care and Medicaid are entitled to comprehensive dental prevention and treatment services, only one in three children enrolled in public insurance accessed dental services last year.

School based dental programs are a proven strategy for reaching children and adolescents at risk of poor dental health. The Center at Central Falls High School provides dental care through a Blackstone Valley Community Health Center. The Centers at Pawtucket's Slater Junior High School and Shea High School provide dental screening through an expansion of the Providence Smiles Program.

The Commission recommends that school based health centers work to add oral health screening and services or referrals into the comprehensive array of primary care services they offer.

8 Initiate a comprehensive review, under the direction of the Children's Cabinet, of all school health services and develop a funding strategy to ensure that each school can meet the medical, behavioral, and oral health needs of its students.

Rationale:

Currently, school districts annually spend $14 million statewide for school nurse teachers, school dentists and physicians, and other school health services. While the scope of this Commission did not include the broader issue of school health services, Commission members recommended that a statewide framework for school health services be developed and implemented.

The framework should address the role of school and community providers in meeting the physical, behavioral, and oral health needs of children and youth. In addition, the framework should reflect best practices related to the continuum of care and the provision of technical assistance. The Children's Cabinet should support policies to ensure coordination of effort and improve service integration.

9 Continue leadership of the School Based Health Center Initiative by the Rhode Island Department of Health in collaboration with other state departments.

Rationale:

The Department of Health has provided leadership for the state's School Based Health Center Initiative for the past 14 years with support from the other state departments.

Each state department plays a vital role. The Department of Human Services should assist efforts to ensure successful integration into Rhode Island's RIte Care environment. The Department of Education should continue to develop the role of schools in addressing physical and behavioral health barriers to learning. The Department of Mental Health, Retardation, and Hospitals and the Department of Children, Youth and Families together should provide leadership for behavioral health services in schools including mental health and substance abuse prevention and treatment services for all Rhode Island youth.

School based health centers are an integral component of the health care system, and as such, need to be considered in relevant health policy discussions. For this reason, the Commission recommends that school based health center leadership and representatives be included in related Commissions such as those involving RIte Care, oral health, and mental health.

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Impact of School Based Health Centers on Health and Education Indicators

School based health centers reduce absenteeism.

Clinic users were absent a lower percentage of the time compared to students who were registered but did not use the clinic as well as students who were not registered for the clinic. McCord, et al., 1993.

School based health centers provide access to critical mental health services.

School based mental health services have the potential for bridging the gap between need and utilization by reaching children who would not otherwise have access to these services. Armbruster, Gerstein, Fallon, 1997.

Adolescents with access to a school based health center were 10 times more likely to make a mental health or substance abuse visit. Kaplan, Calonge, Guernsey, Hanraham, 1998.

A psychosocial screening tool used at a school based health center improved the recognition and treatment of adolescents' mental health problems. Adolescents identified for services with the tool and referred for mental health services significantly decreased their rates of absences and tardiness. Gall et al, 2000.

School based health centers provide access to critical health services.

Average users of the school based health centers (3 visits per year) were representative of the entire student population based on age, race, gender, and grade point average. Frequent users (15 or more visits per year) were likely to be female and have a lower grade point average. Wolk, Kaplan, 1993.

Students who use the school based health center as their primary health care provider were more satisfied with their services compared to users of community or hospital clinics. Kaplan, Brindis, Melinkovich, Naylor, Ahlstrand, 1999.

Elementary students with access to a school based health center had a greater likelihood of having had a physician's visit and a dental examination during the school year than students without access to a school based health center. Kaplan, Brindis, Phibbs, Melinkovich, Naylor, Ahlstrand, 1999.

Uninsured students with access to a school based health center had an easier time obtaining physical health and dental services compared to uninsured students without access to a school based health center. Kaplan, Brindis, Phibbs, Melinkovich, Naylor, Ahlstrand, 1999.

Based on Medicaid expenditures, elementary school students with access to a school based health center had a greater utilization rate for EPSDT services compared to a similar population having no access to a school based health center. Medicaid expenditures were lower for the school based health center group also. Adams, Johnson, 2000.

Repeated chlamydia and gonorrhea screening and treatment in schools with school based health centers are associated with declines in chlamydia presence in boys. Cohen, Nsaumi, Martin, Farley, 1999.

School based health centers can address specific needs of adolescents.

Adolescents have distinct health care access issues. School based health centers can address many of the access issues such as confidentiality concerns, inability to pay, ability of parent/guardian to accompany, and difficulty making an appointment. Ford, Bearman, 1999.

Adolescents who under-utilize services at physicians offices are more likely to be uninsured than any other age group and their physician office visits are shorter. Of those office visits, 49.6% offered no counseling or education. Ziv, Boulet, Slap, 1999.

School based health center access promotes appropriate utilization of the health care system.

There was a significant decrease in emergency department utilization for elementary schoolchildren with access to a school based health center compared to those without access to a school based health center. Kaplan, Brandies, Phibbs, Melinkovich, Naylor, Ahlstrand, 1999.

Adolescents with access to a school based health center had fewer after hours emergency or urgent care visits compared to adolescents without access to a school based health center. Kaplan, Calonge, Guernesey, Hanraham, 1998.

School based health centers can affect a child's use of services and health care expenses. Elementary aged student users had significantly lower inpatient non-emergency department, transportation, drug, and emergency department Medicaid expenses. Medicaid enrolled elementary students using a school based health center had lower emergency department expenditures compared to a similar population without access to a school based health center. Adams, Johnson, 2000.

Creating Access to Care: National School Based Health Center Census, 1998-1999.

The National Assembly on School Based Health Care surveyed 1135 school based health centers, with 806 Centers responding for a 70% response rate. The Census documents findings from the largest data collection and analysis of its kind, and illustrates emerging themes that will assist in program planning, development, and evaluation of school based health centers. Forty-four of the fifty-one states have school based health centers. The report highlights:

- A broad and comprehensive range of primary and mental health care services
- Acceptance of the school based health centers by students and their parents as demonstrated by the Center's enrollment
- An expansion into rural and suburban communities, and middle and elementary grades
- An interdisciplinary health care team model
- An expansive emphasis on prevention through classroom and health center education and health promotion activities
- Operations built upon health professional quality standards, including computerized encounter tracking and third party billing systems, continuous quality improvement mechanisms, and national accreditation

An estimated 1.1 million students (about 2% of the nation's school enrollment) attended a school with a school based health center, with an additional 310,000-750,000 students attending schools linked to a school with a Center.

- 59% of all school based health centers have been established in the last four years
- On average 64% of the student body is enrolled in the school based health centers with 53% of student body having actually visited the Center
- 69% operate more than 30 hours per week
- 48% operate summer hours
- 75% bill Medicaid/third party
- 88% use a computerized encounter system
- 31% are accredited by JCAHO/other
- 34% are certified by the state
- 76% train health professionals on site
- 41% of school based health centers are in high schools, 12% middle, 30% elementary, with the balance in combination schools
- 73% are operated by hospitals, local health departments or community health centers
- 57% provide behavioral health services

Multi-Year Funding Strategy for School Based Health Centers

Fiscal Year	Number of Centers	Total State Core Funding	Potential Number of Students Served
2002	9 (7 existing, 2 new)	$1,125,000	10,677
2003	11 (9 existing, 2 new)	$1,125,000	12,845
2004	13 (11 existing, 2 new)	$1,625,000	15,013
2005	15 (13 existing, 2 new)	$1,875,000	17,181
2006	17 (15 existing, 2 new)	$2,125,000	19,349

Core Financial Support for School Based Health Centers in Rhode Island

Notes on Proposed Prototype Budgets

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January 22, 2001

The resource needs to support school based health centers depend on the types of services being provided and the utilization levels for these services. Utilization, in turn, depends on the size of the schools, the percent of the student body using the Centers, and the characteristics of the students. Clearly, there is great variation in all of these factors in schools in the urban centers of Rhode Island, and even greater variation if we look at all schools in Rhode Island.

In formulating a model for resource use, we have the experience of seven school based health centers that are now operating as well as experience reported by other states. Some data from the Rhode Island Centers have already been presented to the Senate Commission. In this presentation, we will use some of the parameters that can be derived from experience and apply the statistics to a generic model to gain insight into costs of operating a school based health center. The budgets developed here will not reflect any particular operating school based health center. Rather, the focus here will be on future direct costs that need to be covered not only in order to continue the operation of present Centers, but also to support additional Centers in other schools. Both the schools that host the school based health centers and the medical sponsors make substantial in-kind contributions to the Centers.

Estimated Utilization and Service Capacity

The prototype budgets presented here address the provision of ambulatory health services in public schools. The services considered here include services of a nurse practitioner, physician, and mental health/substance abuse counselor, as direct service providers. It is expected that these professionals will work with other school personnel to provide the needed array of services. Based on the reported productivity of school based health center personnel in Rhode Island and in other states, the estimated service capacity of school based health center personnel is given in the table below.

Table 1
Service Capacity of School Based Health Center Personnel

Position	Hours per Week	Visits per Hour	Visits per Year
Nurse Practitioner	25 hours	2 visits	1,800 visits
SBHC Coordinator	-	-	-
Physician	3 hours	2 visits	216 visits
MH/SA Counselor	25 hours	1 visit	900 visits
Health Educator	-	-	-
Risk Reduction Counselor	-	-	-
Nutritionist	-	-	-
Totals	**53 hours**		**2,916 visits**

Table 1 shows the average service capacity of a school based health center staffed by a full-time nurse practitioner, a full-time mental health/substance abuse counselor, and a part-time physician. This level of staffing would support about 2,916 visits per year.

Experience in Rhode Island and in other places indicated that utilization per enrollee can be expected to be about 1.5 visits per year for elementary school; about 2.0 visits per year for junior high or middle school; and about 3.0 visits per year for senior high schools. These rates, of course, will vary with the characteristics of the students. Experience also suggests that 60 percent of the students will be enrolled in the school based health centers. Based on these parameters, the expected visits of schools at different levels can be projected. The following table shows these estimates.

The size of the school enrollment shown here is limited to the approximate range of school sizes that we have in Rhode Island except that some allowance is made for schools which are located near to each other to share facilities. Shared facilities are being used in both Pawtucket and Woonsocket.

Prototype Budgets by Level of Service Capacity

The capabilities of school based health center personnel and the expected utilization of the Centers provide a basis for making some budget projections. The proposed core budget would support about 2,900 visits using both a full-time nurse practitioner and a full-time counselor. If one of the larger Rhode Island high schools had average utilization, it is expected that this level of staffing would need to be increased and supported with additional funds or with resources provided outside the school based health center budget.

The prototype budget outlined below is based on personnel salaries for a 10 month school year at average prevailing rates, and providing for services during normal school hours. Either extending the work week or the work year would, of course, increase the budget. Other costs are based on the average experience of existing school based health centers.

Table 2
Estimated Visits by School Type and Size

School Enrollment	Elementary School	Junior High School	Senior High School
500	450 visits	600 visits	900 visits
750	675 visits	900 visits	1,350 visits
1,000	900 visits	1,200 visits	1,800 visits
1,250		1,500 visits	2,250 visits
1,500		1,800 visits	2,700 visits
1,750			3,150 visits
2,000			3,600 visits

Table 3
Prototype Budget - FY 2002
School Based Health Center Costs

Personnel Expenses	**FTE**	**Direct**	**Indirect**	**Total**
Nurse Practitioner	1.0	$ 50,000		$50,000
SBHC Manager (bilingual)	1.0	$ 25,000		$25,000
MH/SA Counselor	1.0	$ 40,000		$40,000
Physician	0.1		$10,000	$10,000
Specialty Care Provider	0.1	$ 5,000		$ 5,000
Health Educator	Collaboration			
Risk Reduction Counselor	Collaboration			
Nutritionist	Collaboration			
Outreach*	0	$ 0	$ 0	$ 0
Salary Expense	0	$120,000	$10,000	$130,000
Fringes @ 25%		$ 30,000	$ 2,500	$ 32,500
Personnel Costs		$150,000	$12,500	$162,500
Other Direct Expenses				
Medical Supplies		$ 4,000		$ 4,000
Office Supplies		$ 3,000		$ 3,000
Lab and X-ray		$ 1,000	$ 2,000	$ 3,000
Pharmacy		$ 2,200	$ 800	$ 3,000
Translation Services		$ 300	$ 300	$600
Telephone		$ 1,500	$ 1,500	
Travel		$ 800	$ 800	
Printing		$ 600	$ 400	$ 1,000
Postage		$ 400	$ 400	$ 800
Equipment Maintenance		$ 500	$ 500	
Medical Waste Disposal		$ 1,800	$ 1,800	
Other Core Costs		$ 14,600	$ 5,400	$ 20,000
Administrative Expenses				
Medical Provider Administration & Support			$ 7,500	$ 7,500
School Administration & Support (Principal, School Nurse/Teacher, COZ Coordinator, Central Administration, etc.)			$14,000	$ 14,000
Space, Utilities, Janitorial			$ 5,000	$ 5,000
Administrative Costs			$26,500	$26,500
Total Costs		**$164,600**	**$44,400**	**$209,000**

*Outreach includes activities to enroll students in the school based health center and to utilize the services. It also includes assistance to uninsured children to enroll in RIte Care. Federal medical assistance law requires the state to fund enrollment activities at health centers and hospitals. The Departments of Health and Human Services currently provide funding for these activities to the health centers and hospitals that are the medical providers of school based health centers.

The budget outlined above assumes that both schools and sponsoring medical organizations make in-kind contributions to support the Centers. For example, it is expected that the schools provide space, utilities, janitorial services, additional supplies, other school department personnel such as school psychologists or counselors, and so forth. It is also expected that the sponsoring medical organizations will contribute overhead support and specific services such as billing and provision of 24/7 coverage and coverage of students when school is not in session if the students choose the school based health center as their primary care provider.

Revenue Sources for School Based Health Centers

Sources of revenues for school based health centers are expected to vary by more than costs vary. In general, it is expected that the state will provide some core funding. Some reimbursement is available from health insurance and other third party sources. Both school departments and medical providers are making substantial in-kind contributions to existing Centers.

The Department of Human Services is currently working with school systems to increase the amount of reimbursement that they receive from Medicaid (or RIte Care) for qualified services and through administrative claiming. It is expected that this will be the source of some cash revenues that may be used to help support school based health centers.

Even with core state support, it is expected that both schools and their medical partners will be important sources of financial support. It should be noted that both schools and the medical providers are under increasing pressure as public expectations for the provision of more and better services are surpassing the growth of their revenues.